It is perhaps unsurprising that medical students of this generation emphasize care delivery within the context of technology. Rapid diagnoses, lab values and detailed descriptions of medical conditions now emerge within seconds of simply touching a screen. The age-old adage of “sticking to the books” thus remains foreign to many of us, as we so rarely rely on them.

Our argument for technology in the healthcare setting provides a conveniently convincing argument for purchasing iPads and iPhones. I recall coercing my then apprehensive parents into purchasing an iPad for me, since it would help with my learning. Applications like *UptoDate* and *Epocrates*, luxuries I would “struggle” without, would facilitate better care provision as I would be able to meet specific needs for my patients. Aside from the array of useful medical texts, references, and applications, I would also be able to retreat to Netflix and iTunes when I had minutes to spare, a detail I selectively ignored in my pitch.

Though I felt some degree of guilt for not using my iPad solely for medical purposes, I did recognize and exercise its academic potential when I started seeing patients on the wards. A side effect or a bizarre presentation would light a match to my investigative inquiry. As a result of this tool, I found myself probing my residents less for knowledge, personalizing my learning plans, and creating a stepwise approach to diagnosis. The iPad, to no one’s surprise, became an appendage I could not do without.

However, it was not until my Psychiatry rotation that I began to see the catch 22 in my pre-held bias. It was the beginning of my time on the adult inpatient ward and I was assigned to the Mood/Psychosis floor. The patient I was requested to see was floridly psychotic on admission, claiming to fear cloaked figures standing outside her window. This constellation of manic and depressive symptoms, coupled with underlying suicidal ideation, made the afternoon before me quite foreboding.

I recall entering the room cautiously, worrying that I would be unable to assess the patient’s capacity. The chart I was navigating had numerous lab values, admission notes, and data collected from previous providers. Amidst this web of pertinent positives, negatives and several differential diagnoses was the patient, Rachel, who proceeded to oddly welcome my entrance into the room.

As I attempted to take a seat near her bedside, the patient looked at me kindly, gesturing that I come closer. She then muttered quietly to herself, acknowledging that she was ready to see me.

“Hi Rachel,” I said nervously. “I’m here today to check in with you. The attending mentioned that the facility hasn’t provided you with what you’ve desired and I’d like to try my best to help. Could we begin with you telling me a bit about yourself?”

At this point, I reached into my white coat to secure my iPad, preparing to jot down a few notes. It had almost become reflexive for me to retrieve this element in my arsenal, forgetting that my eyes and attention were not focused where they should have been – on the patient.

“Well, you’ve seen my chart and you know why I’m here,” she began. “I’ve been depressed for a while, especially since I was a young child. It hasn’t been easy and that’s why I don’t think I can hang on much longer.”

The patient continued on to discuss her first episode of sexual abuse, a violent and forced rape, and the early birth of her unplanned child. She described the harsh reality of being a single mother, continually blaming herself for her mistakes in the process. She elaborated on her financial difficulties and the unstable nature of her child’s father. Throughout this, she reflected upon her knowledge of her problem, indicating that she needed help. I, however, failed to address this adequately.

 “Do you even know why I want to die?” she said.

I was startled. I had never been labeled as dismissive and this was an outright attack on my attentiveness, or lack thereof. My instinct was to defend my actions, but I then realized I could not. In the one hour I interviewed the patient, I looked up at her for validation a handful of times. In that same hour, I failed to ask meaningful questions, as I was more engrossed in filling out my iPad physical diagnosis application rather than listening to what she had to say.

As I placed my iPad down, not attempting to retreat to its use, I looked at the teary-eyed patient. I apologized deeply for the discomfort I caused her, assuring her that I was just trying to be a good caretaker. But, she remained refractory to my apology. She said I wasn’t the first to do this to her and that this was a common trend she saw in her providers. To add to our difficulty, she decided she wanted nothing more than to not see any of us again.

It saddened me to think that I contributed to an escalating problem we face or will face in coming generations. As more and more providers become technologically proficient, they become simultaneously socially and emotionally deficient. Through spending time typing notes and developing a plan for my patient, I compromised my capacity to really listen and hear what my patient was feeling. But, I suppose that this is what happens, when iThink iCare.